



- Between the Lakes**
- Blue Ridge Women’s Center**
- Clemson-Seneca Pediatrics**
- Keowee Family Urology**
- Mountain Lakes Internal Medicine**

- Oconee Heart Center**
- Oconee Kidney Center**
- Rheumatology Consultants**
- Seneca Medical Associates**
- Upstate Family Medicine**
- Upstate Surgical Associates**

Release of Information Authorization Form

Acknowledgement of Receipt of Notice of Privacy Practices and Financial Policy

This signed form acknowledges that you have received a copy of our practice’s Notice of Privacy Practices as required by Federal Law and our Financial Policy. By signing below you are acknowledging that you understand and have read the notices. The notices are yours to keep.

With whom may we discuss patient’s financial information?

Patient Only: []

Name: _____ Relationship: _____

Name: _____ Relationship: _____

May we leave messages regarding appointments?

(Messages regarding any other information will be left as call back request only)

YES

NO

_____ What Phone Number

With whom may we discuss patient’s medical information?

Patient Only: []

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I give permission to the following person(s) to bring my child in for an appointment:

Parents Only: []

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Print Patient Name

Patient Date of Birth



Signature of Guarantor/ Patient/ Legal Guardian

Date

This authorization is in effect until revoked in writing.